Refer to: Denson TA, Manning PR: Current problems in medical practice as viewed by California physicians (Information). West J Med 1982 Apr; 136:369-372

Information

Current Problems in Medical Practice

As Viewed by California Physicians

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THE CENTRAL MISSION of medicine, to prevent and cure disease and to reduce human suffering, rests on accurate diagnosis, effective therapy, a good doctor-patient relationship, public health measures and the competence of all health-care personnel. As scientific advances, governmental regulations and social policies make patient care more complex, problems emerge that must be continually scrutinized if we are to provide optimal medical care. Accordingly, we asked a group of physicians to rank the most serious problems encountered in their practice.

Methods

The Instrument

To design a survey instrument for this purpose with the least bias, we first used an open-ended approach in which 179 physicians attending postgraduate courses sponsored by the University of Southern California gave free-form answers to the question: "What are the three most serious problems (both medical and nonmedical) in your practice?" From the answers collected, we created a simple questionnaire that would produce information in an assessable form by grouping the open-ended responses into 25 categories. The most serious problems stated by a second group of 98 physician attendees were similarly grouped into these 25 categories. Three physicians then cross-validated the placement of individual problems into the categories, with 72 percent agreement. The few problems that did not fit into the 25 categories were placed in a 26th and labeled "other."

The 26 categories were listed in a simple checklist which, together with the instructions, was pilot tested for clarity. The physicians were asked to rank the three most serious problems as 1, 2 or 3. After minor changes, the final version (see Figure 1) was arranged in a self-mailer format. The retest reliability of the questionnaire was examined among two separate groups of physicians, with 79 percent (n=89) agreement in problem selection over a five-day interval and 59 percent (n=41) agreement over a three-week interval.

Subjects

In 1980 the California Medical Association (CMA) had 24,865 active members representing 36 specialties and subspecialties. We selected 18 specialties and subspecialties with a combined membership of 18,583 physicians for our survey. Using membership lists in which CMA members were grouped by zip code within specialties, we took every fifth name for a total sample of 4,448 physicians, which we deemed representative of the membership's specialties and geographic distribution. (The sample size is not exactly one fifth of the membership because each specialty and subspecialty group was a separate sampling frame. These sampling frames varied in size, and a "random start" technique was used to select the sample.)

Of the physicians who received our questionnaire, 1,704 (39 percent) gave usable responses to the first mailing. A second mailing to those who did not respond increased the total number of usable responses to 2,745 (62 percent). Only 83 responses were deemed unusable because of failure to follow directions. Chi-square analyses showed the responding sample to be representative of both the specialties and the geographic distribution of California's physicians.

Analysis

We counted the number of respondents for each item chosen as one of the three most serious problems. The item chosen most frequently by the 2,745 respondents was then given a rank of 1, the next most frequently chosen was ranked 2

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Supported by a grant (103) from the California Medical Education and Research Foundation and the W. K. Kellogg Foundation.

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and so forth through all 26 items. For example, "government regulation of medical practice" was cited as the most serious problem by 604 respondents, the second most serious by 464 respondents and the third most serious problem by 239 respondents, for a total of 1,307 citations. Based on this total the item ranked first among the 26 problems on the questionnaire.

We also calculated a weighted score for each item by multiplying the relative importance assigned to the item by the number of respondents assigning that level of importance to the item. The rankings resulting from this procedure had a correlation of rho = 0.992 with the simple frequency count. Since the two analyses correlated so highly, we report only the results of the frequency count, in the interest of simplicity.

Results

Table 1 shows the 26 problem categories listed in the order of their frequency. The rankings do not, of course, indicate the distance that the physicians perceive between any two of the items on any absolute scale of importance, but they do indicate what problems are considered most serious to this group of physicians in California.

Of the 86 problems in the "other" category (less than 1 percent of the total number of responses), the only items recurring with reasonable frequency were a physician surplus or patient

PROBLEMS IN PRACTICE

When asked to describe the major problems they face in practice, over 200 physicians have identified the problems listed below. Please read the list and decide upon the THREE MOST SIGNIFICANT PROBLEMS in your practice. In the space next to those three problems, write a "1" next to the most significant problem, a "2" next to the second most significant problem, and a "3" next to the third most significant problem. You may use the space below each item to describe details of the problems.

PLEASE RANK ONLY YOUR TOP THREE PROBLEMS. If one or more of your major problems does not fit into the categories, mark "OTHER" and briefly describe the problem in the space provided.

_____ Relationships with colleagues	_____ Patient compliance
_____ Practice coverage	_____ Concern for malpractice
_____ Non-M.D. health care professionals	_____ Negative influence of media on patients (TV, news, etc.)
_____ Hospital policies and/or hospital administration	_____ The telephone
_____ Regulatory agencies (JCAH, etc.)	_____ The demanding patient
_____ Third Party payers	_____ Patient education
_____ Government regulation of medical practice	_____ Legal and ethical issues
_____ Personnel selection/supervision	_____ Charts/record-keeping
_____ Paperwork	_____ Cost containment for the benefit of patients
_____ Financial management of practice	_____ Patient-related time commitments
_____ Diagnosis	_____ Personal time management
_____ Therapy	_____ Continuing medical education
_____ Doctor-Patient relationship	_____ OTHER: (Please describe)

Figure 1.—Questionnaire used in survey.

TABLE 1.—*Current Problems in Medical Practice as Seen by Physicians*

Rank	Number Reporting	Problem
1	1,307	Government regulation of medical practice
2	915	Paperwork
3	801	Concern for malpractice
4	673	Third-party payers
5	504	Regulatory agencies (including JCAH)
6	472	Cost containment for patient benefit
7	344	Personal time management
8	326	Hospital policies
9	324	Negative influence of media on patients
10	313	Financial management of practice
	* * *	
11	245	Charts and record keeping
12.5*	234	Personnel selection/supervision
12.5*	234	The telephone
14	220	The demanding patient
15	215	Patient-related time commitments
16	180	Non-MD health care professionals
17	165	Legal and ethical issues
18	162	Continuing medical education
19	144	Relationships with colleagues
20	136	Practice coverage
21	98	Patient compliance
22	79	Other (listed separately)
23	58	Patient education
24	43	Diagnosis
25	28	Therapy
26	21	Doctor-patient relationship

JCAH=Joint Commission on Accreditation of Hospitals

*Denotes tied ranks.

shortage in certain geographic areas or specialties (n=16) and concerns about possible "competition between private physicians and HMO's" (n=9).

Discussion

From previous studies, we expected that nonmedical problems such as administrative and organization problems would be mentioned more often than medical problems, even though the latter are central to the practice of medicine.[1,2] We were, however, startled at the relative infrequency of diagnosis, therapy and the doctor-patient relationship, the raison d'etre for medicine, which ranked 24, 25 and 26, respectively, among the 26 categories. In fact, only one item (cost containment for patient benefit) among the top ten mentioned is directly related to patient care. Nor did the ten most common problems include such items directly related to patient care as charts and record keeping, the demanding patient, patient education, or legal and ethical issues. On the surface at least, physicians seem to be most concerned with societal and governmental regulatory pressure and, to a lesser extent, with managing their time and relating to the medical establishment.

The 25 items undoubtedly were interpreted somewhat differently by different physicians, so strict reliance on our ranking from 1 to 26 is not warranted. Nevertheless, the magnitude of the frequency of selection of less direct aspects of patient care is so great in contrast to the infrequency of selection of "diagnosis, prescription and doctor-patient relationships" as to warrant considering several nonmedical problems to be distractions from, if not actual barriers to, optimal medical care.

The fact that the 2,745 physicians surveyed cited nonmedical aspects of practice much more often than "medical" problems raises several broad and significant questions:

- Do the time and concern that physicians spend on nonmedical problems significantly impede health care?
- Do nonmedical issues such as government regulations actually improve patient care and thus offset physicians' dissatisfaction with them?
- Do nonmedical issues predominate as problems because little or no attention is given them in medical school or continuing education?
- How can undergraduate and continuing education address the problems most often mentioned?

Optimists and pessimists may draw different conclusions from this study. Optimists may reason that diagnosis and therapy, the primary medical mission, are handled so effectively as not to cause serious concern. Pessimists may conclude that nonmedical problems in patient care have become so onerous and overwhelming that they distract physicians from their primary mission. Even though we favor the second conclusion, we remain surprised at the frequency with which the physicians mentioned nonmedical problems as serious difficulties in their practice. Until the questions we have raised are answered we must assume that the nonmedical problems are real and possibly harmful to patient care.

Summary

To determine the most serious problems in medical practice as viewed by physicians, we asked 2,745 members of the California Medical Association, "What are the most serious problems (medical and nonmedical) that you experience in practice?" The five most frequently stated prob-

lems (government regulations of medical practice, paperwork, concern for malpractice, third-party payers, regulatory agencies) were not directly related to the care of patients. Diagnosis, therapy and the doctor-patient relationship—the essential core of medical practice—ranked respectively 24, 25 and 26 in frequency among 26 categories. Physicians thus seem to be concerned primarily by nonmedical problems. The weight of these nonmedical problems in practice may be barriers to optimal patient care by distracting physicians from the performance of their primary mission.

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Refer to: Naeim F, Froetscher L, Hirschberg GG: Treatment of the chronic iliolumbar syndrome by infiltration of the iliolumbar ligament (Information). West J Med 1982 Apr; 136:372-374

Information

Treatment of the Chronic Iliolumbar Syndrome by Infiltration of the Iliolumbar Ligament

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THIS STUDY ATTEMPTS to establish the respective value of local infiltrations with lidocaine alone and lidocaine mixed with dextrose in the treatment of the chronic iliolumbar syndrome (ILS).

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This syndrome has been described as a distinct low back pain syndrome with typical unilateral findings of low back pain produced by the hip flexion test and the Patrick test.[1] There is also an exquisitely tender point at the posterior iliac crest. The chronic form of this syndrome responds very poorly to the common methods of treatment of low back pain such as rest, analgesics, heat and other forms of physical therapy, and it is frequently aggravated by pelvic traction. Whether or not the patient is treated, there are remissions and exacerbations which may continue for a lifetime. Many patients complain of a constant ache that is aggravated by prolonged sitting and standing. The onset frequently follows a lifting accident or a fall.

Most likely the chronic ILS is the result of soft tissue injuries to the iliolumbar ligament and constitutes the most common form of low back sprain. However, sometimes it is found to be associated with a radiculopathy and some authors believe that all backache is discogenic in origin. The clinical features have also been attributed to a facet syndrome in the lower dorsal area.[2] For this reason we prefer the word "syndrome" to "sprain."

Historical Review

Therapeutic Use of Local Anesthetics

As early as 1930, Leriche pointed out that after infiltration of a tender ligament or tendon with procaine there was not only temporary relief of discomfort but a more prolonged effect than what one would expect from the anesthesia. After repeated infiltrations of the painful tendon or ligament with procaine, Leriche actually reported complete recovery.[3] In the United States this method was first described by Steinbrocker.[4] Travell in numerous publications has reported relief of musculoskeletal pain in many areas of the body by the infiltration of "trigger points" with procaine.[5-7] Travell's explanation of this therapeutic effect is that the anesthetic breaks a chronic pain cycle. More recently Steinbrocker preferred the use of lidocaine because of its prolonged effect and lesser chance of allergic reaction.[8]

Therapeutic Use of Sclerosing Agents

The use of hypertonic dextrose is an outgrowth of the theory of musculoskeletal pain developed by Hackett.[9] This author postulates that the pain is caused by a microscopic tear in a ligament or